MULTIPLE BILLING OVERRIDE CERTIFICATION COUNTY: [] DUPLICATE ERROR CORRECTION DATE: [] ADP 1584 FORMS CLAIM FOR MONTH/YEAR PROGRAM CODE: FISCAL YEAR:_ Please complete this certification form (for override code "Y") for multiple services provided to a client for the same day. TYPE OF CLAIM ID PROV AND LINE BATCH CLIENT NAME SERVICE SERVICE UNITS CODE NUMBER NUMBER PROVIDED DATE BILLED REASON (last, first Initial) OVERRIDE REASON: 1. The client could not receive all necessary services at one time. The client record clearly documents the date and time of day each visit was made and that the return visit was not a hardship on the client. 2. Crisis visit. Services are documented in client record.

- 3. Collateral services. Services are documented in client record.
- 4. This service has been erroneously billed and has been reported to the Department of Alcohol and Drug Programs, by the provider, on disallowance form ADP 5035B. (A copy of the disallowance form must be attached)
- 5. This is a duplicate claim due to a key entry error by the state (a copy of the original claim and the error correction report must be attached).

I hereby certify that I am authorized to represent the county. I recognize that the services specified above have been identified by the automated Short-Doyle/Medi-Cal claim processing system as those which are potentially duplicative or otherwise inappropriate. I further certify that I have reviewed the client record specified above and have determined that the services billed were necessary and appropriate.

Signature:	Date:	
Title:		
RETAIN THE ORIGINAL CERTIFICATION ALONG WITH THE MONTHLY CLAIM OR THE ERROR CORRE	CTION REPORT NOTED	ABOVE

THIS DOCUMENT MUST BE PRODUCED ON DEMAND FOR AUDIT OR SITE VISIT BY ADP.

ADP 7700 (Revised 5/97)

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